Borderline Personality Disorder in the Primary Care Setting

Amelia N. Dubovsky, MD\textsuperscript{a,}\textsuperscript{*}, Meghan M. Kiefer, MD\textsuperscript{b}

KEYWORDS

- Borderline personality disorder
- Primary care
- Psychopharmacology
- Behavioral problems
- Personality disorder
- Management of borderline personality disorder

KEY POINTS

- Borderline personality disorder is a commonly encountered problem in primary care settings.
- The disorder is characterized by interpersonal problems, which often play out in the relationship between doctor and patient.
- The underlying cause of the disorder is multifactorial, and includes both brain abnormalities, genetics, and experiences early in life.
- The doctor–patient relationship can be greatly improved by better physician understanding of the disorder, good communication with all involved providers, minimization of polypharmacy, and learning how to respond to commonly encountered behavioral problems.

CASE

The first person on the morning’s clinic schedule is a 27-year-old woman, Jane, who arrives 10 minutes late, accompanied by her boyfriend. She unfolds a piece of paper with jotted notes and tells you that, “I am really sick, Doc,” and proceeds to relay an array of complaints ranging from migraine disorder, chronic back pain, and urinary incontinence. When you attempt to orient yourself by asking what prompted her transition in care, she laughs and tells you she has moved from another state for her boyfriend. She smokes cigarettes and reports taking sertraline, olanzapine, topiramate, and clonazepam, all of she tells you require refills today: “I’m out of everything.”

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\textsuperscript{a} Department of Psychiatry and Behavioral Sciences, Harborview Medical Center, University of Washington School of Medicine, 325 9th Avenue, Box 359896, Seattle, WA 98104, USA; \textsuperscript{b} Division of General Internal Medicine, University of Washington General Internal Medicine Center, University of Washington School of Medicine, Box 354760, Seattle, WA 98195-4750, USA
\textsuperscript{*} Corresponding author.
E-mail address: ameliand@uw.edu

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When you inquire about the indications for her medications, she abruptly becomes tearful, telling you, “I need them to live after my sister died. I think about dying to be with her, but I have to stay.” She endorses prior history of suicide attempt with acetaminophen, which required hospitalization, and reports she began cutting herself beginning in the 8th grade “to relieve stress.” She then returns to discussing her migraine disorder and tells you, “My doctor in Arizona was really good, she knew all about this stuff,” and requests an urgent referral to neurology.

**EPIDEMIOLOGY**

- Borderline personality disorder (BPD) is common in the primary care setting.
- Higher rates are documented in specific illnesses (chronic pain, migraine).

Estimates of the prevalence of BPD vary significantly based on the setting. BPD has a lifetime prevalence of up to 6% in the US population\(^1\) with a 12-month period prevalence of approximately 1.6%,\(^2\) and affects men and women equally overall. Prevalence is higher in younger adults, those with lower incomes and education, and shows racial and ethnic variability (higher in Native American men, lower in Asian women and Hispanic persons.)

Both life experience and genetics are thought to play a role in this disorder, and a family history of BPD is often present.\(^3,4\) The majority of persons with BPD report a history of some type of childhood abuse, including sexual abuse and/or neglect.\(^5\) However, although common, a history of trauma is not always present in patients with BPD.

In the primary care setting, BPD prevalence is estimated at 6%,\(^6\) with a prevalence of nearly 10% in the outpatient psychiatry setting.\(^7\) However, this disorder often goes undiagnosed by primary care providers, and those with BPD are less likely to be recognized as suffering from emotional or psychiatric problems by their providers than those with other psychiatric disorders.

BPD prevalence has been shown to be higher among certain populations, affecting an estimated 18% of chronic pain patients and 26% of depressed primary care patients.\(^8,9\) In one study of patients diagnosed with BPD presenting for psychiatric care, the prevalence rate of severe headache was 60%, with half of women and nearly one quarter of men reporting a diagnosis of migraine, a rate several times that found in the general population.\(^10\) Given the complexities of the patient–provider relationship with BPD, managing these medical conditions in this frequently encountered setting can be challenging. Further, management of physical health in persons with BPD can be made more challenging by higher rates of unhealthy behaviors, such as smoking, excess alcohol intake, and increased risk taking.\(^11\) Illustrating the dilemma, in one study, 27% of outpatients who met criteria for BPD self-reported misuse/abuse of prescription drugs.

BPD is associated with increased medical and psychiatric utilization and health care expenditures.\(^12\) However, a significant proportion of the costs associated with BPD are owing to the significant financial burden of decreased productivity.\(^13,14\) The unhealthy and risky behaviors noted are likely to be a factor in both medical and nonmedical costs.

**REMISSION**

- Remission rates are high, but relapse can occur.
- Remission of diagnostic criteria does not always indicate functional improvement.

Consistent with the decreasing prevalence with age noted, many patients initially diagnosed with BPD are found to improve symptomatically, with many no longer
meeting criteria over time. In contrast with mood disorders, which may remit rapidly but often recur, it seems that BPD is relatively slow to remit but recurrence is less common.

Estimates of BPD remission are variable and reflect the heterogeneity of the patient population and remission criteria; however, several studies suggest that at 2 years’ follow-up, 35% to 45% of BPD patients will no longer meet criteria, and the majority of patients will be in remission by 10 years’ follow-up. Relapse rates also vary by follow-up time, but estimates range from 6% to 15%. Not surprisingly, those patients who have been in remission for a longer period of time are more likely to maintain it. It is important to note that remission by diagnostic criteria does not necessarily indicate increased functioning; rates of recovery/improvement of global function are low even among those who have achieved remission, with 75% lacking full-time employment and approximately 40% receiving disability payments. However, patients who have achieved remission from BPD are more likely to report improved health status and healthier behaviors.

In 1 inpatient study, 7 variables were noted to be significant predictors of successful remission when adjusting for other factors: Younger age, absence of childhood sexual abuse, no family history of substance use disorder, good vocational record, absence of an anxious cluster personality disorder, low neuroticism, and high agreeableness. In another cohort of 100 patients, remission was estimated at 75% by 15 years follow-up, and 93% by 27 years follow-up, although nearly 20% of the cohort was deceased by that time, over half by suicide.

**SUICIDE**

- Although much of the suicidal behavior in BPD does not lead to completed suicide, suicide remains a major cause of death for this population.

Suicidal behavior (defined as any action that could potentially cause one to die) is found in approximately 80% of BPD patients, a substantial increase from the general population, with 60% to 70% of patients engaging in suicide attempts. A history of self-injurious behavior doubles the risk for suicide among BPD patients, but affective instability is also associated with increased suicide attempts. The risk of suicide for persons diagnosed with BPD is estimated at 8% to 10%. This suicide rate is 50 times higher than that of the general population; it is estimated that BPD may account for 18% of all US suicides.

**CRITERIA AND CLINICAL CHARACTERISTICS**

- Definition and characteristics of BPD.

BPD is characterized by a longstanding, pervasive pattern of instability in interpersonal relationships, identity, impulsivity, and affect. The criteria for the diagnosis of BPD can be found in the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition. One of the most useful ways to make the diagnosis is by asking patients if they believe the criteria characterize them. Repeated suicidal threats or acts, unstable relationships, and fear of abandonment are highly associated with the diagnosis. Nonsuicidal self-injurious behavior is common in these patients.

There are 4 categories into which the features of BPD can be classified: Interpersonal hypersensitivity and unstable relationships, affective dysregulation, impulsivity, and disturbed cognition. Interpersonal hypersensitivity and unstable relationships are a hallmark of BPD. Patients with this condition tend to be extremely sensitive to rejection and have a preoccupation with abandonment. They often have unrealistic
expectations of others in relationships (especially professional relationships, as with doctors and therapists), and develop increased emotional instability when the relationship inevitably disappoints them or when rejection is perceived. In the primary care setting, this disappointment can take the form of the physician being unavailable when the patient expects (e.g., for last-minute appointments, unscheduled refills of medications, or after-hour phone calls). This can be confusing for the primary care provider, who previously was idealized by the patient as “the only person who understands me,” and now is devalued as “the worst doctor I’ve ever had” after a perceived minor disappointment.

Affective dysregulation is characterized by a range of intense emotions including rage, shame, sorrow, panic, emptiness, and loneliness, often all experienced multiple times within a single day. Although such episodes seem unpredictable and out of the blue, they are often preceded by interpersonal conflict.

Impulsivity can take the form of impulsive suicidal behaviors, as well as impulsive substance use, binge eating, spending sprees, verbal outbursts, and reckless driving. This type of impulsivity is different from the impulsive behavior exhibited during manic episodes, which is more prolonged and is accompanied by other symptoms of mania, such as grandiosity, pressured speech, and lack of need for sleep.

Disturbed cognition can be further divided into three categories: (1) disturbed but nonpsychotic thoughts, such as dissociation, depersonalization, derealization, and intense feelings of guilt or shame, (2) transitory, loosely reality-based delusions and hallucinations (such as thinking others are talking about them in a malicious way), and (3) frank hallucinations and delusions. Some form of disturbed thinking is experienced by almost all individuals with BPD; outright psychosis is much less common and transitory, when it does occur.

COMORBIDITY

- Associated with other psychiatric disorders.
- Associated with worse outcomes in Axis I disorders.

Individuals with BPD have a high comorbidity with Axis I and II psychiatric disorders: 84.5% meet criteria for an Axis I disorder in the past 12 months and 73.9% meet criteria for another lifetime Axis II disorder. BPD is most highly associated with mood disorders, anxiety disorders, and substance misuse disorders. In addition, patients with BPD are often misdiagnosed with bipolar disorder or major depressive disorder. In contrast with the mood episodes associated with major depression and bipolar disorder, mood episodes with BPD are often short lived (several episodes of dysphoria and euthymia occurring in 1 day), without sustained periods of mania or elation. Mood swings are common with interpersonal difficulty or rejection. It was previously thought that trauma was among the most significant predictors for the development of BPD. However BPD has an approximate 30% comorbidity with post-traumatic stress disorder, and it is now known that BPD often develops without a history of trauma.

Unfortunately, patients with BPD often have worse outcomes with their comorbid psychiatric disorders. BPD patients are twice as likely to have ongoing substance use disorders at 3 years’ follow-up when adjusting for other risk factors, and patients with BPD and comorbid substance use have an increased mortality risk compared with others with substance use disorders. BPD may also be a risk factor for major depression persistence.

As is true of mood and anxiety disorders, BPD is associated with increased morbidity and mortality of medical disorders, such as cardiovascular disease and
Frankenburg and Zanarini compared patients with remitted and nonremitted BPD and found that patients with nonremitted illness were more likely to have fibromyalgia, chronic fatigue, and temporomandibular joint syndrome, as well as a history of obesity, osteoarthritis, diabetes, hypertension, back pain, and urinary incontinence. These findings were consistent with a 10-year follow-up study. El-Gabalawy and colleagues used the National Epidemiologic Survey on Alcohol and Related Conditions Wave 2 to look at the comorbidity of medical disorders in a large number of individuals (2231) suffering from BPD. The authors found that the presence of BPD (after controlling for other Axis I and II disorders as well as socioeconomic variables) was significantly associated with arteriosclerosis or hypertension, hepatic disease, cardiovascular disease, gastrointestinal disease, arthritis, and sexually transmitted infections. The authors also found that individuals with BPD and cardiovascular disease, sexually transmitted infections, and “any assessed physical health condition” have a greater likelihood of attempting suicide compared with those with BPD alone. Obesity and the metabolic syndrome have also been found to have an increased incidence in individuals with BPD, especially women. This could be partially explained by side effects of atypical antipsychotics prescribed in this population compounded by poor self-care and unhealthy behaviors.

PATHOPHYSIOLOGY

- Multiple contributing factors.

Although the exact cause of BPD is unknown, the origins of the illness are likely multifactorial and can be divided into putative genetic causes, brain abnormalities, neurohormonal factors, and environmental influences.

**Genetics**

Previously, it was thought that environmental factors such as early adverse childhood experiences were the sole cause of BPD; however, it is now known that the cause of BPD also involves genetic factors. Although no specific genes have been identified, BPD is significantly inheritable: Torgensen and colleagues found that BPD has 68% heritability. Additional twin studies have shown heritability ranges from 0.65 to 0.75.

**Brain Abnormalities**

Although results have been inconsistent, individuals with BPD have shown reduced volume in the amygdala on magnetic resonance imaging. They also exhibit varied (some studies indicate increased, some decreased) amygdala activation on functional magnetic resonance imaging when processing negative emotions. Despite inconsistent data, it is likely that the amygdala is somehow altered in patients with BPD, indicating that the limbic system processes emotional information differently than patients without BPD. Evidence has also been found that there is altered metabolism in prefrontal regions, including the anterior cingulate cortex, which could partially explain these individuals’ propensity toward impulsivity.

**Neurohormones**

There has been evidence that altered activity of neuropeptides, including oxytocin and opioids, may play a role in mediating some of the symptoms of BPD, including affective reactivity and anger outbursts.
Environmental Factors

Negative events during childhood, such as trauma, abuse, or neglect, in addition to insecure attachment, can contribute to the development of BPD, although they are usually not the sole reason for developing BPD. It seems more likely that an interaction between negative childhood experiences, genetics, and brain function abnormalities lead to the development of BPD. What is clear is that it is not helpful to conceptualize these patients simply as “victims” of trauma.

TREATMENT

- Psychotherapy is the mainstay of treatment.
- Manualized, structured forms of therapy are more effective.
- Psychopharmacology can be used to treat symptoms, but polypharmacy should be avoided if possible.

In the past, BPD has been viewed as a disorder that is largely untreatable, but it is now becoming apparent that it has a better than expected prognosis and has even been referred to “the good-prognosis diagnosis” by Zanarini after studying the patient population over 10 years.

The primary treatment for BPD is psychotherapy, although not all forms of psychotherapy are equally effective. Traditional psychoanalytic therapy can even be harmful to the patient, so it is important to help the patient find the appropriate treatment. Psychopharmacology should be seen as an adjunctive treatment, rather than the primary treatment.

Psychotherapy

There are 4 types of empirically studied treatments for BPD: Dialectic behavior therapy (DBT), mentalization-based therapy, transference-focused psychotherapy, and general psychiatric management, which are all manualized (meaning the therapy has been tested, is highly structured, and the therapist and patient closely follow a manual throughout the treatment), making it easier to assess therapists’ adherence to the treatment. Although these treatments are becoming more available than in the past, they require therapists to undergo extensive training and are not always easily accessible by patients. These treatments also require therapists to be self-aware and have access to consultation by other colleagues to avoid burnout. DBT, a manual-based 1-year outpatient treatment involving group and individual therapy is perhaps among the most well-known and effective treatments for BPD. DBT focuses on teaching the patient how to manage self-destructive feelings and behaviors. Additionally, the DBT therapist helps the patient to regulate emotion, and develop reality testing and interpersonal effectiveness through various techniques, including distress tolerance, acceptance, and mindfulness. It has been found to reduce self-harm and suicidality in addition to lowering health care costs and utilization of emergency department and inpatient admission. Mentalization-based therapy is another group and individual manualized therapy. Treatment is focused on helping the patient to “mentalize” or understand the mental state of oneself and others and to think before reacting. Transference-focused psychotherapy is an individual, twice-weekly therapy derived from psychoanalysis. It is focused on transference (feelings of the patient projected onto the therapist), and is among the more difficult techniques to learn. General psychiatric management is a once-weekly psychodynamic therapy. It focuses on the patient’s interpersonal relationships and can also include pharmacotherapy and family therapy. This is the most available and easiest to learn, although is also
the least well-validated. In general, effective treatment requires the patient’s active involvement and commitment (Table 1).

**Psychopharmacology**

Polypharmacy is a common problem encountered in patients with BPD. In a study by Zanarini and colleagues, 62% of patients with the disorder were taking medications regularly, and over 40% were taking 3 or more standing medications. However, evidence for psychopharmacology in this population is scant. Selective serotonin reuptake inhibitors are commonly prescribed to patients with BPD, but have little benefit over placebo in randomized, controlled trials.63 However, they can be helpful if comorbid depression is present. Of all antidepressants, there has only been 1 study that showed a positive effect for amitriptyline in the reduction of depressive symptoms.64 Caution should be taken with patients who are prone to suicide attempts, because tricyclic antidepressants like amitriptyline can be lethal in overdose. The use of benzodiazepines in BPD is controversial. Although there are no data to support the use of benzodiazepines in the treatment of BPD, these medications are commonly used to treat anxiety and emotional lability. However, they have not been shown to be effective for reducing the hallmarks of BPD, particularly self-harm behavior, and have not been shown to improve outcomes. Benzodiazepines are also commonly used in overdose. The limited data available suggest that benzodiazepines can be associated with increased emotional lability and suicidality in patients with BPD.65 If deemed necessary, benzodiazepines should only be used with great care, in low doses, and ideally in conjunction with psychotherapy. Of the anticonvulsants, beneficial effects have been found for valproate, lamotrigine, and topiramate. Valproate has been shown to decrease interpersonal problems and depression.66,67 Lamotrigine is commonly used for augmentation of depression treatment in clinical practice, but has only

<table>
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<th>Table 1</th>
<th>Psychotherapy strategies for borderline personality disorder</th>
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<tr>
<td><strong>Therapy</strong></td>
<td><strong>Structure</strong></td>
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<tr>
<td>Dialectic behavior therapy</td>
<td>Yearlong outpatient treatment</td>
</tr>
<tr>
<td></td>
<td>Group and individual therapy</td>
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<tr>
<td></td>
<td>Manual-based</td>
</tr>
<tr>
<td></td>
<td>Focus on distress tolerance, emotional regulation, mindfulness</td>
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<tr>
<td>Mentalized behavior therapy</td>
<td>Group and individual therapy</td>
</tr>
<tr>
<td></td>
<td>Manual-based</td>
</tr>
<tr>
<td></td>
<td>Focus on understanding the mental state of self and others, reflection before reaction</td>
</tr>
<tr>
<td>Transference focused</td>
<td>Focuses on individual’s feelings projected onto therapist</td>
</tr>
<tr>
<td>Psychodynamic therapy</td>
<td>Weekly individual sessions</td>
</tr>
<tr>
<td></td>
<td>Focus on interpersonal relationships</td>
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</table>
been shown to improve impulsivity in long-term follow-up.\textsuperscript{68,69} Antipsychotics are also frequently used in patients with BPD both for psychotic symptoms and management of mood instability, although it is important to take into consideration the risk of obesity and the metabolic syndrome associated, especially with second-generation antipsychotics. In comparison with placebo, haloperidol has been shown to reduce symptoms of anger.\textsuperscript{64,70} Olanzapine has been shown to reduce affective instability, anger, and psychotic symptoms.\textsuperscript{71} In a study of 52 patients, aripiprazole was found to significantly reduce symptoms of anger, psychosis, impulsivity, and interpersonal problems as well as depression and anxiety.\textsuperscript{72} Ziprasidone has not been shown to have any beneficial effect (\textit{Table 2}).\textsuperscript{73}

**MANAGEMENT IN THE PRIMARY CARE SETTING**

- Setting clear boundaries is critical.
- Set regular scheduled appointments for check-ins, rather than only seeing the patient during crises.
- Communicate with all providers involved.

BPD is associated with use of greater numbers of primary care physicians, increased use of medical office visits, telephone calls to medical offices, and medication prescriptions.\textsuperscript{74,75} Often this increased utilization of services represents patients seeking dependent relationships as substitutes for poor parenting. Although treating patients with BPD in the outpatient primary care setting can be extremely challenging, providers can often feel much less frustrated if they have a better understanding of BPD.\textsuperscript{6} It is important to recognize that “difficult” behavior is often driven by underlying fears of abandonment. Treatment of these patients is best done in the context of a team of providers, including an individual therapist, group therapist, and psychiatrist, if possible. However, many patients refuse psychiatric referral or even consultation.

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<th>Pharmacologic Class</th>
<th>Specific Agents</th>
<th>Advantage/Disadvantages</th>
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<tbody>
<tr>
<td>Antipsychotics</td>
<td>Haloperidol: ↓ anger symptoms</td>
<td>Can reduce psychotic symptoms and/or act as mood stabilizer</td>
</tr>
<tr>
<td></td>
<td>Olanzapine: ↓ mood instability, ↓ anger</td>
<td>Increased risk of obesity, metabolic syndrome</td>
</tr>
<tr>
<td></td>
<td>Aripiprazole: ↓ anger, impulsivity, interpersonal problems, ↓ depression/anxiety</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ziprasidone: no demonstrated effect</td>
<td></td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Valproate: ↓ interpersonal problems, depression</td>
<td>Can help with mood stabilization</td>
</tr>
<tr>
<td></td>
<td>Lamotrigine: ↓ depression (added to other prescription), ↓ impulsivity</td>
<td>Valproate requires monitoring</td>
</tr>
<tr>
<td>SSRIs/SNRIs</td>
<td>No SSRI or SNRI has been proven more effective than another</td>
<td>Limited evidence for benefit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Useful if comorbid depression present</td>
</tr>
<tr>
<td>TCAs</td>
<td>Amitriptyline: ↓ depressive symptoms</td>
<td>Caution with patients at risk of overdose</td>
</tr>
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\textit{Abbreviations:} SNRI, serotonin and norepinephrine reuptake inhibitor; SSRI, selective serotonin reuptake inhibitor; TCA, tricyclic antidepressant.
because they experience the suggestion as rejection. Consultation may be facilitated by reassuring the patient that the primary physician will continue treatment. Communication between providers (especially those prescribing medications) is crucial, especially in minimizing overprescribing of potentially dangerous medications in light of the frequency of suicidal behaviors.

One of the most important factors in treating patients with BPD is setting clear boundaries and expectations for all parties involved at the beginning of a treatment relationship. This serves to minimize the amount of perceived abandonment that occurs, although will likely still occur. Clear boundaries provide a holding environment for the patient and reduce physician burnout. It is important to set up regular, scheduled appointments to reassure the patient that even if he or she becomes “well,” the physician will not abandon the patient, which is often the motivation behind treatment resistance. Although participation of patients in a highly structured treatment such as DBT or mentalization-based therapy is ideal, this is not always feasible owing to cost, availability of such specialized treatments in the area, and patient willingness to participate. Regardless of the type of treatment the patient is participating in, it is crucial for the primary care physician to not be the sole provider of all medical and psychiatric care. Box 1 contains tips on how to manage patients with BPD in the primary care setting. Although patients with BPD have been found to display an increased propensity toward disruptive behaviors in the clinical setting, primarily resulting from impulsive anger, they do not have an increased incidence of violent behavior.

It is important to remember when treating patients with BPD that the disorder is extremely stigmatized, even among mental health providers. This is primarily owing to lack of education about the disorder, limited empirical data on treatment, and the lack of adequate resources to treat these individuals. It is important to remember that manipulative behavior often occurs in response to expected abandonment and

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Box 1

Tips for the management of borderline personality disorder in the primary care setting

1. Learn about common clinical presentations and causes of undesirable behavior.
2. Validate the patient’s feelings by naming the emotion you suspect, such as fear of abandonment, anger, shame, and so on, before addressing the “facts” of the situation and acknowledge the real stresses in the patient’s situation.
3. Avoid responding to provocative behavior.
4. Schedule regular, time-limited visits that are not contingent on the patient being “sick.”
5. Set clear boundaries at the beginning of the treatment relationship and do not respond to attempts to operate outside of these boundaries unless it is a true emergency.
6. Make open communication with all other providers a condition of treatment.
7. Avoid polypharmacy and large-volume prescriptions of potentially toxic medications (including tricyclic antidepressants, cardiac medications, and benzodiazepines).
8. Avoid prescribing potentially addicting medications such as benzodiazepines, opiates, or other controlled substances. Inform patients of your policies regarding these medications early in the treatment relationship so they are aware of your limits.
9. Set firm limits on manipulative behavior while avoiding being judgmental.
10. Do not reward difficult behavior with more contact and attention. Provide attention based on a regular schedule rather than being contingent on behavior.
Table 3
Common behavioral problems associated with borderline personality disorder encountered in the primary care setting and their management

<table>
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<tr>
<th>Clinical Scenario</th>
<th>Management Strategy</th>
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<tr>
<td>Follow-up with patient “Jane”</td>
<td>With the patient’s help, pick the most urgent matter and address only that today. Review clinic policy requiring review of outside records before providing refills of psychoactive substances such as benzodiazepines. Set up a follow-up appointment for next week to address additional concerns. If patient’s use of suicidal statements increase, refer to the emergency room because she is an unfamiliar patient to you.</td>
</tr>
<tr>
<td>The patient has called the clinic 7 times in 1 d demanding to speak to the doctor, and refusing to specify the reason for calling. She has a regularly scheduled appointment for the next day. She has engaged in abusive and threatening language with the staff when they inquire her reason for calling.</td>
<td>Remind the patient that you will see her the next day for her appointment. Speak in a calm and even tone; do not engage in arguing or admonishing her over the phone. Cut off contact if patient escalates. During her appointment remind her of the clinic policies about abusive language toward staff; remind her that abusive behavior in the future will result in her termination from the clinic. Move on to discuss medical problems without further judgment or scolding tone.</td>
</tr>
<tr>
<td>The patient requests a refill for Adderall &quot;just this one time&quot; that her psychiatrist normally prescribes because he is out of town and the hard copy of the prescription was stolen by a friend.</td>
<td>Do not refill the prescription because this will set a precedent for further boundary limit testing in the future. Tell patient it is a clinic policy that you do not refill prescriptions written by another doctor no matter what the circumstances, and that she will need to contact her psychiatrist when he is back in town.</td>
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</table>
The patient has received a prescription for oxycodone after a visit to the emergency department for a migraine. She comes to the office in tears requesting a refill for the medication because “this is the only medication that has ever helped my pain.”

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<tr>
<th>Do not refill the prescription. Acknowledge the patient’s distress (“you are very upset right now”). Firmly state that it is against your policy to prescribe opioids for migraines.</th>
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The patient presents with symptoms she feels indicate a serious illness, despite a pattern of similar complaints leading to repeated evaluations without evidence of significant pathology. When you attempt reassurance, she demands elaborate testing to confirm “I know there’s something wrong.”

<table>
<thead>
<tr>
<th>Briefly see and evaluate the patient and provide reassurance that there is no infection present. Validate the patient that she is suffering and uncomfortable, and that you will continue to follow her symptoms. Schedule a regular follow-up appointment. Remind her ahead of time that you will only be available to her only during regularly scheduled appointments. Do not acquiesce to requests to repeat invasive medical tests or provide treatment that is not indicated.</th>
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</table>

You have secured an outpatient psychiatry consultation for the patient, but she refuses to go “because they won’t understand me like you do.”

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<th>Discuss fears about seeing the psychiatrist including fear of abandonment by you (the primary care provider); provide reassurance that you will continue to treat her despite another physician being involved. If recurrent maladaptive behavior continues to disrupt the doctor–patient relationship, tell the patient that consultation is necessary if treatment is to continue.</th>
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may be managed by strict limit setting and consistent availability that is not contingent on expressions of distress.

Referral to emergency psychiatric services (emergency room or psychiatric crisis center) should be considered if the patient has new or changing thoughts about suicide, or if these thoughts increase in intensity or frequency, and/or if the patient expresses desire or intent to act on impulses rather than having fleeting thoughts of suicide (Table 3).

FUTURE DIRECTIONS

BPD is a commonly encountered disorder in the primary care setting. Despite the difficulty in the management of these patients, with a good understanding of the illness, support from other providers, and clear boundaries, relationships can be extremely rewarding to both parties involved, and the primary care physician can make a significant impact in these patients’ lives. With the implementation of the Affordable Care Act, it is possible that more patients will be able to obtain access to specialized psychiatric services, including structured therapy, which can result in not only a reduction in symptoms, but a remittance of the disorder altogether.

REFERENCES


